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ABSTRACT

An inservice program for Australian teachers, which involved clinical supervision methods, was evaluated to examine its effectiveness. Clinical supervision seeks to promote a form of teacher development that is descriptive and formative. Teachers were involved in a process of assisted self-reflection about their teaching, with the aid of a colleague (i.e. "supervisor") who listened supportively to plans before a lesson, and followed through by collecting an observational record of classroom issues and events of interest to the teacher. This activity was seen as a systematic, critical, and reflective process, assisting teachers to articulate their aspirations and teaching intents, collecting data about the teacher's area of classroom interest, collaboratively analyzing the data for what they revealed, and formulating and implementing future action strategies. Being able to exercise governance over what passed as inservice education, particularly being able to ensure that it was an integral and on-going part of actual teaching, was considered by teachers to be the greatest benefit of clinical supervision. (JD)

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TEACHING AS LEARNING: SOME LESSONS FOR STAFF DEVELOPMENT FROM CLINICAL SUPERVISION

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Introduction

A continual problem confronting us as educational researchers is how to show that any particular practices have an impact on student learning. Part of the problem lies in the number and complexity of interacting variables, but it also has to do with the distal nature of those variables to actual learning processes. Methods of working with teachers to improve teaching is a typical example. If it is difficult to show that different teaching strategies make a difference, then it is practically impossible to show that particular modes of in-service education have differential effects on learning. Notwithstanding this difficulty, knowledge is beginning to accumulate about how we might better work with teachers to enhance their professional development (Smyth, 1982a). Some indications will be provided in the remainder of this paper on what has been learned in three years of field work, about one mode of classroom-based in-service education. Two questions are addressed: firstly, what have our experiences revealed about the process of 'clinical supervision', and secondly, what has been learned about the implementation of the process with teachers? While I do not have definitive answers to either question, the fifty teachers we have worked with in varying degrees of intensity (both primary and secondary, experienced and inexperienced), have been generous in the serendipitous sharing of their thoughts, feelings and impressions about the process. It is these I want to share with you here.

Research reported here was supported by grants from E.R.D.C. Educational Research and Development Committee, Canberra, Australia and Deakin University. My appreciation to Mr Colin Henry for involvement in the fieldwork.

.... Becoming 'Clinical'

When Goldhammer (1969) and Cogan (1973) and associates pioneered clinical supervision at Harvard University in the 1950's, they had a clear vision of what they were trying to do. They were searching for an alternative to existing artificial and contrived methods of providing in-service education to teachers. They were disillusioned with existing practices that separated teachers from the realities of teaching and classrooms, and which treated them as having deficiencies that had to be remedied. Then, as now, it makes sense to focus in-service around issues of immediacy and practicality to individual teachers. Twenty years later (Anderson, Krajewski and Goldhammer, 1980), the mentors regret using the label 'clinical' because of the troublesome medical connotation. What is important, however, is the construct behind the label. Behind the metaphor is a process that enables teachers to reflect and become more aware of their own teaching "in the clinic of the classroom" (Cogan, 1973, p. ix).

Through systematic discussion and observation clinical supervision seeks to promote a form of teacher development that is descriptive and formative, as opposed to inferential, value-laden and summative. Teachers are involved in a process of assisted self-reflection about their teaching (Beasley, 1981), with the aid of a colleague (i.e. a 'supervisor'), who listens supportively to plans before a lesson, and follows this through by collecting an observational record of classroom issues and events of interest to the teacher. It is, therefore, a systematic, critical and reflective process of assisting teachers to articulate their aspirations and teaching intents, collecting data about the teacher's area of classroom interest, collaboratively analysing the data for what they reveal, and formulating and implementing future action strategies.

The process is predicated on a shared framework of meaning based on a desire to effect an authentic collegial relationship between practising teachers (Smyth, 1982b). Within a complete cycle of clinical supervision there are four phases:-

Pre-observation conference: teacher and supervisory colleague collaboratively discuss the teacher's plan for a forthcoming lesson (objectives, teaching strategies, intended learning outcomes, etc.);

Observation: the teacher proceeds with the lesson while the supervisor observes and records relevant data;

Analysis: after the lesson, teacher and supervisor separately reflect on the lesson; the teacher in a self-analytical fashion, the supervisor with the benefit of data which are sorted preparatory to discussion with the teacher;

Post-observation conference: the teacher indicates impressions about the agreed focus of the lesson, and the supervisor assists the teacher to check those impressions against the data. Together they begin planning for a further cycle, or action to be trialled, implemented and monitored.

.... About the Process

The aspect that has loomed largest in our own research of the clinical supervision process has been the issue of control, in its various forms. Teachers are impressed with the way clinical supervision provides them with a real sense of control - both over their in-service education and their classroom teaching. For many teachers, carefully examining their own practice is an uplifting process - they begin to see that teaching need no longer remain an impulsive, routine or a technical activity. They can discover much about themselves as teachers in a context where they exercise real 'ownership'. It is not outside experts who call the shots or dictate the pace. After brief familiarisation with the process, it is they who decide who they shall work with; who will enact which role, and for how long; when, where and how often lessons shall be observed; at what pace they shall work; what they shall focus upon; how the data shall be collected; what inferences shall be drawn from the data; and what changes (if any) shall be made as a consequence. In brief, teachers begin to realise they can be genuine and conscious agents in the enhancement of their own learning about teaching.

Compared to the ubiquitous in-service 'day', clinical supervision enables teachers to engage in dialogue with colleagues about real situations, and in so doing gain active control over their own learning. They feel comfortable with the classroom-embedded on-the-job approach because it satisfies an

element of immediacy within teaching itself. It provides them with prompt feedback about their own teaching. Before they were introduced to clinical supervision these teachers were often able to tell us when teaching went well or badly, but discussing the specifics was a lot more problematic. Because of the complexity of classrooms, and without feedback from others, teachers were forced to rely on intuition. Clinical supervision, for these teachers, was like opening a door:

> (It) allows a person to look and see what he is actually doing in the classroom. It is the mirror of his present teaching behavior. It gives the teacher objective information about his role in the classroom and enables the teacher to learn as much as he can about his own methods of working with and influencing children.
>
> (Bodine, 1973, p. 171)

Aside from initial anxieties about being observed by someone else while teaching, or feelings of inadequacy as an observer, once teachers see the utility of data collected about their teaching, they become more deliberately reflective about their own and each other's teaching. They move from an analysis of their own teaching based on impressions, to a situation where reflection becomes a much more integral part of teaching itself. Discovering unknown aspects about their own teaching and selectively trialling and monitoring new possibilities, enables teachers to gain greater control over their classroom practice.

We learned a lot about the importance of acknowledging the realities of schools and classrooms. Often educationists expect teachers to engage in well-intentioned but impossible activities. While clinical supervision does not endorse the view that 'anything goes', it does recognise that teachers' existing practices should be the starting point. That someone else could actually look at their practice in a non-judgemental non-evaluative way, was novel to many teachers. They saw clinical supervision as severing the link between classroom observation, and inspection and quality control. They were impressed by its potential for not only alerting them to aspects of teaching needing attention, but also because of its possibilities for affirmation of sound aspects of their teaching. It gave them insights into <u>how</u> and <u>why</u> particular practices worked, or did not!

Teachers responded to the realism of the process; thinking about teaching beforehand, collecting information, and analysing what occurred, was what 'good' teachers did anyway! Having a colleague help them initiate and follow through the process meant that reflection about teaching was likely to be both more rigorous and certain. They felt this form of assisted self-reflection to be both realistic, worthwhile and purposeful - it was more likely to lead to changes in their teaching. They aknowledged that there was no automatic presumption about change - merely that as they came to think more carefully and deliberately about their practice, there was a greater likelihood they may want to modify their practice. As Feiman (1981) noted, "self-awareness increases the teacher's control over his/her actions and the possibility that he/she will modify them" (pp. 18-19).

.... About the Implementation of the Process

We have gained insights into what happens when attempts are made to implement schemes like clinical supervision in schools. For instance, we are convinced that change in schools is a slow incremental process that occurs on a broken front. It is unrealistic for example, to try and involve an entire school staff in clinical supervision. It is not that kind of technique. Its success depends primarily on the intimacy and trust between individual teachers. Imposing it upon people within schools without careful consideration to the negotiation of access of those most affected, and the implications for the school at large, is a recipe for disaster (Henry, 1981). It works best where small numbers of teachers, who trust each other, decide to 'give it a try' (Smyth, Henry & Martin, 1982). It spreads when these teachers, who have first-hand knowledge, demonstrate its potency to other teachers. Involvement is therefore episodic and piecemeal within schools. We like to see that as a sign of its strength, rather than a weakness.

It was interesting to note that a number of teachers who were skeptical, even hostile at the beginning, showed noticeable changes once they saw clinical supervision gave them insights into their own teaching, and that pupils benefitted as well. For these teachers clinical supervision seemed to be an important way of re-thinking many of their approaches to teaching.

As we worked with these teachers we found, like Peshkin (1982) that our own research agenda was being subtly shaped from, "who are these people and

what are they doing?", to "who are these people and what are they doing to us?". This became clear when teachers started to question our own sincerity and credentials - did we use clinical supervision in our own teaching, when, how often, with what result? We found ourselves rejecting the notion of one day workshops on clinical supervision that were heavy on information-giving, in favour of a strategy that drew heavily on the experiences of teachers. During a preliminary workshop (which they attended with a 'working' colleague) teachers were briefly introduced to the formalities of clinical supervision (rationale, intent and strategies), and required to 'think through' in small group discussion, a commitment to try out the practice on some aspect of their own teaching. This was not a role play - it was for real! After viewing a video tape of us doing clinical supervision on our teaching, individuals were required to articulate the aspect of their teaching to be looked at upon return to school, who was to enact the respective roles, how the data would be collected, what they would tell the rest of the staff, and any anticipated problems (timetabling, etc.). Upon returning to schools, they carried through their plans over a period of weeks, taking particular note of their own reactions to the process, what it seemed to be doing to them, their relationships with partners, other staff and students. They attended a follow-up workshop four weeks later to provide them with an opportunity to exchange experiences, highlight joys and frustrations, indicate adaptations, and to plan for further school involvement. Explaining their particular school context, their own personal feelings, how they had actually implemented clinical supervision, and their impressions about its efficacy, appeared to be a satisfying experience in itself for many of these teachers.

Reflecting on our own mode of working with teachers, we were implicitly, if at times unwittingly, endorsing much of what research says about how adults learn. Our approach was life-centred and experientially-based (Willie & Howey, 1981). It started with the needs and interests of participants (Hunt, 1978), while acknowledging that individuals have differing needs to be self-directing through collaboration (Knowles, 1978). The extended and developmental nature of workshop encounters with their careful balance between demonstration, theory and practice, helped teachers to make sense of their new experiences (McNergney & Carrier, 1981) through personal support during what amounted to a threatening challenge to their existing practice (Sprinthall & Sprinthall, 1980). Contrary to what usually happens in in-service activities, we were emphasising tacit information and experiential knowledge, rather than abstract, general or theoretical knowledge (Feiman, 1981).

Conclusion

Possibly the most important lesson we have learned from our fieldwork with teachers using clinical supervision as a classroom-based approach to in-service education, is the real meaning of "collegiality." We were certainly mindful of Garman's (1982) point that collegiality refers to the "posture of the people who become involved. . .(or) the mental baggage they bring with them as they work together" (p. 38). While it is easy enough to preach to teachers the virtue of adopting such a posture, we realized that unless our own mode of working with teachers was genuinely collaborative in nature, then our efforts were likely to have little impact.

Being able to exercise governance over what passed as in-service education, particularly being able to ensure that it was an integral and on-going part of actual teaching, was considered by teachers to be the greatest benefit of clinical supervision. They found themselves able to gain control over their teaching in a way that had previously been impossible. They no longer had to rely on vague impressions as to how their teaching was proceeding. In short, the message we have consistently received from teachers is that clinical supervision constitutes for them what Hutson (1981) has described as "best practices in in-service education."

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